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What women want: Exploring pregnant women's preferences for alternative models of maternity care

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ABSTRACT

Depending on obstetric risk, maternity care may be provided in one of two locations at hospital level: a consultant-led unit (CLU) or a midwifery-led unit (MLU). Care in a MLU is sparsely provided in Ireland, comprising as few as two units out of a total 21 maternity units. Given its potential for greater efficiencies of care and cost-savings for the state, there has been an increased interest to expand MLUs in Ireland. Yet, very little is known about women's preferences for midwifery-led care, and whether they would utilise this service when presented with the choice of delivering in a CLU or MLU. This study seeks to involve women in the future planning of maternity care by investigating their preferences for care and subsequent motivations when choosing place of birth. Qualitative research is undertaken to explore maternal preferences for these different models of care. Women only revealed a preference for the MLU when co-located with a CLU due to its close proximity to medical services. However, the results suggest women do not have a clear preference for either model of care, but rather a hybrid model of care which encompasses features of both consultant- and midwifery-led care.

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1. Introduction

In 2012, the Irish government outlined a strategic framework for reform of the health service [1]. Ensuring patients are treated at the lowest level of complexity is a major tenet of this reform. This can be achieved within maternity care where there currently exists an imbalance

between provided and required care. According to the National Institute for Health and Care Excellence (NICE) guidelines [2], the vast majority of pregnancies would be classified as low risk, but occur in settings that are designed to deal with moderate to high risk pregnancies. Treating women at the lowest level of complexity could be achieved by moving the majority of these pregnancies away from hospital settings to low risk settings, such as a midwifery-led unit (MLU), which is safe and cost-effective [3,4]. In a MLU, midwives are solely responsible for care and the full range of medical services is not immediately available, but can be accessed either through an alongside obstetric unit,

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or consultant-led unit (CLU), or by transfer if the MLU is not co-located with a CLU, referred to as a free-standing MLU.

In many developed countries, these birth settings are offered to women considered at low risk of obstetric complications. Current clinical guidelines in the UK espouse that choice of alongside and free-standing MLUs should be provided to women with straightforward pregnancies [2]. In New Zealand, women have the choice of delivering in a hospital or community birth centre, such as a free-standing MLU. Continuity of care is a core tenet of national policy in New Zealand, allowing women to also choose their preferred caregiver for the duration of their pregnancy [5]. Australia has reformed its own national policy to encourage greater use of alternative low risk birth settings, affording women with a choice of consultant- and midwifery-led models of care [6]. Similar choices are available in other countries, most notably the Netherlands where maternity care has evolved around the midwife who acts as a gate-keeper of consultant-led care. Although, in the Netherlands, the choice of birth setting is limited to midwifery-led care and home birth care. Obstetricians are only involved in maternity care in the event of an obstetric complication requiring medical intervention [7].

Whereas midwifery-led care has a long standing tradition in many countries, the service is a relatively new departure in maternity service provision in Ireland. It was introduced in 2004 following the recommendations of a State-commissioned review group [8]. Two alongside MLUs were installed alongside two existing CLUs on a trial basis, which found that adverse outcomes occurred uniformly across both models of care [3,4]. The trial also found that interventions during childbirth were fewer in a MLU and a normal birth in a MLU saved the state €57 compared with a normal birth in a CLU. The results echoed international evidence [9–12], and have been the subject of widespread discussion and research in recent years [13–16].

Nevertheless, maternity care in Ireland remains heavily medicalised [17]. Currently, over 99% of births in Ireland are recorded in maternity units, with home births accounting for 0.3% of all births [18]. Intervention during childbirth is at its highest level ever with the rate of Caesarean section accounting for 29% of all live births in 2013 [18]. This has increased from 25.2% in 2004. Operative vaginal deliveries have also increased over the same period, while spontaneous vaginal births have fallen by 5.3% in absolute terms [18]. This must be considered in the context of good perinatal outcomes which are comparable to other countries with similarly high intervention rates [18,19]. The level of resource use is amplified by the intertwining nature of Ireland's public and private health care systems where private patients, who pay out-of-pocket for maternity care (both directly and indirectly), are more likely to deliver by Caesarean section or vacuum- and forceps-assisted delivery than public patients, who receive their care free of charge under the Maternity and Infant Care Scheme [20]. High intervention rates affect hospital and State finances. In Ireland, the cost of a Caesarean section is estimated at €4095 in a CLU [21], while a spontaneous vaginal birth is considerably less at €627–€631 [4,21]. In contrast, a spontaneous vaginal birth in an alongside MLU is estimated at €564 [4].

In spite of the safety [22,23] and cost-effectiveness [4] evidence in favour of midwifery-led care, the development of MLUs in Ireland has been slow, limited to the two alongside MLUs that were established in 2004 [24]. A midwifery-led maternity service has emerged and become common place across some major maternity units. This service (referred to as a Domiciliary In and Out of Hospital scheme, or DOMINO scheme) typically provides midwifery-led antenatal care in a community setting and intrapartum care in a CLU [16]. However, there has been an increased interest among policymakers, clinicians, and the wider public to expand midwifery-led care in Ireland [15,16,25] and, in 2015, the Irish government committed to reforming maternity service provision by expanding MLUs across the country [26].

However, pregnant women have yet to be given a voice on their preferences for the different models of care on a national basis. Byrne et al [13] explored preferences among a group of women attending a large Dublin maternity unit ($n = 501$). The authors found that 43% of the group would prefer to deliver in an alongside MLU, whereas 46% and 2% would prefer to deliver in a CLU or at home, respectively. However, the sample was skewed towards women with high risk pregnancies (79.5% of total sample) who may have had a disposition towards consultant-led care due to their risk status. Thus, research on the preferences of low risk women has gone largely unexplored. The primary goal of this research was to identify the different aspects of care that influenced women's decision-making when presented with the choice of delivering in a CLU or MLU. This study precedes a larger, quantitative study which investigated demand for these models of maternity care in Ireland; research which is forthcoming by these authors.

2. Materials and methods

This study employed a qualitative approach to investigate the features of maternity care that influence pregnant women's decision-making when presented with the choice of delivering in a CLU or MLU. Focus groups were employed rather than individual interviews to ensure that wide ranging ideas emerged and debate among participants ensued. Group settings are known to have a synergistic effect over one-to-one interview settings [27].

The criteria for inclusion were restricted to women who were considered to be at low risk of obstetric complications, and who were currently beyond 20 weeks gestation. Low risk was defined by NICE guidelines [28]. Women who were considered high risk were excluded as they do not have the choice to deliver in a low risk setting.

A sample group of women who had recently had their 20 week scan (over a two week period during May, 2012) and who were booked to deliver in a large, teaching maternity hospital in Cork, Ireland, were invited to participate in the focus groups. We selected 20 weeks as our minimum gestation period due to concerns about confirming a viable pregnancy. It was also important that we captured preferences as early as we could during the antenatal period as we wanted to ensure that recent experiences (positive or negative) did not unduly influence preferences. 196 low risk women were identified from the hospital's antenatal

tal database records. 138 (70.4%) women were receiving their care publicly whereas 58 (29.6%) women were receiving their care privately. An invitation letter, accompanied by an information leaflet, was distributed to the full sample. Women were only asked to attend one session. Public and private patients alike were interviewed in the focus groups to provide an all-encompassing view of women's preferences for alternative models of maternity care. From a policy perspective, it was important to capture the views of all potential maternity care users as a change in service provision may displace other services. In this way, it was interesting to understand the motivations of women that opted for private care, and explore whether they would be interested in an alternative, inexpensive model of care, such as midwifery-led care.

Four focus groups were arranged with participants in the teaching maternity hospital in May 2012, where each session was audio recorded and women gave written consent to participate in the study. Each focus group was facilitated by two (non-medically trained) researchers: a lead facilitator and a co-facilitator. The lead facilitator was the same across each focus group, while the co-facilitator varied. To ensure consistency, the lead facilitator directed the focus groups, while the co-facilitator provided support, assisting with questions and understanding where necessary. Ethical approval for this study was granted by the Clinical Research Ethics Committee and the Division of Obstetrics and Gynaecology in Cork University Maternity Hospital (ECM4 06/03/12).

A topic guide that described a list of features of maternity care which might influence women's decision-making when choosing place of birth was prepared prior to the focus groups. The topic guide derived from an extensive review of existing literature, which examined women's preferences for maternity care [29–31], preferred place of birth [7,13,32–35], and the factors that influence decision-making when choosing place of birth [36,37]. We also included policy-relevant issues to Ireland by exploring women's preferences for free-standing versus alongside MLUs. It served as a prompt in the focus groups where women were asked to consider each aspect of care and its influence on their decision-making when presented with the choice of delivering in a CLU or MLU. As such, the focus groups were semi-structured; women were asked specific questions but were allowed to digress from the topic guide to ensure other aspects of care that may have been missed were subsequently captured. For simplicity, the structure of the focus groups followed that of a pregnancy (i.e., we started by asking questions about antenatal care, then intrapartum care, and finished by asking questions about postnatal care). (The topic guide is available as Supplementary material.)

A thematic analysis was undertaken to evaluate the different aspects of maternity care that drive women's decision-making when choosing place of birth. The thematic analysis followed five key stages to identify themes in the data [38]. Firstly, iterative reading of the transcripts and individual transcripts was undertaken; a transcript represents the overall set of responses per focus group, while the individual transcript represents the transcript of each participant's responses. Secondly, codes were gener-

Table 1

Characteristics of focus group participants (n = 19).

Mean age in years (range)	32.3 (25–38)
Median number of births	1
Parity	
Nulliparous	9
Multiparous	11
Nationality	
Irish	14
Non-Irish	5
Coverage	
Public	11
Private	8

ated to describe salient and relevant themes. The relevant data items were collated in the third stage using mind maps and tables. The candidate themes were continuously refined during the fourth stage to ensure that an appropriate and coherent pattern was evident. This involved further coding and the generation of new themes through the amalgamation and removal of certain data items. The emerging themes and subthemes were defined during the fifth stage.

3. Results

3.1. Participants

Of the 196 women invited to participate in the study, contact was made with 168 women (85.7%). 28 women had either changed address or incorrectly specified their telephone number. Although 37 women (22.0%) agreed to participate in the focus groups, 19 women (11.3%) were available during the scheduled focus group sessions. Between three and seven women participated in each focus group. Participant characteristics are outlined in Table 1. Each group session lasted approximately one hour and thirty minutes.

3.2. Thematic analysis

During the course of the focus groups, participants described their preferences for various features of maternity care. Five themes were identified during the early stage of the analysis: health care provider (type of carer), fear of obstetric complications, fear of pain associated with childbirth, fear around timely access to vital services, and women's involvement in decision-making during labour. Through iterative refinements, the candidate set of themes was reduced from five themes to three, with three themes (fear of obstetric complications, fear of pain during labour, fears around access to vital services) collapsing into one single theme: fears around childbirth (Fig. 1). Other themes were refined, while several subthemes were combined to represent emerging patterns within each theme. The three main themes identified in this analysis were continuity of care from antenatal to intrapartum care; fears around childbirth; and freedom to exercise choice (Fig. 2).

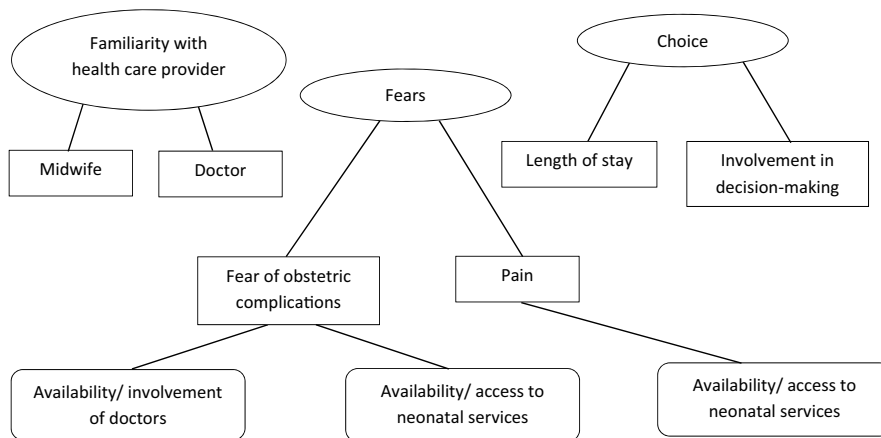


Fig. 1. Refined thematic map depicting three main themes.

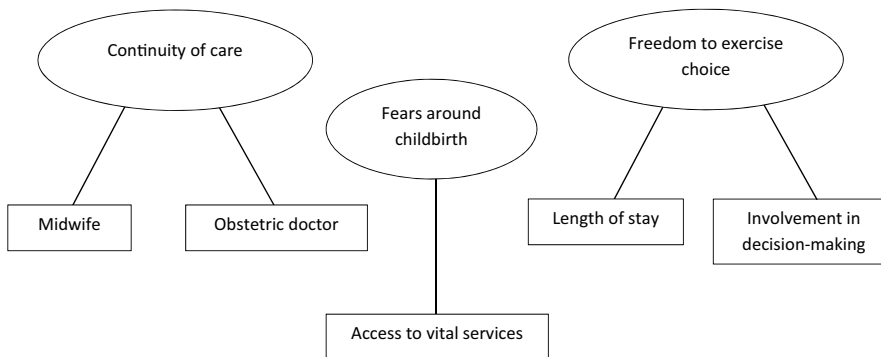


Fig. 2. Final thematic map depicting three main themes.

3.2.1. Continuity of care from antenatal to intrapartum care

3.2.1.1. Role of the midwife and obstetric doctor. Participants were asked about the role of the midwife and obstetrician during antenatal and intrapartum care. There were some differing views around participant's preferred health care provider; however, continuity of carer, provided by either a midwife or obstetrician, emerged in each area of discussion. Women who preferred midwife-led care felt that the midwife played an essential role during antenatal care and care during labour.

I think the midwife is very important, I mean they run the show really. Participant 3, multiparous, public.

The importance and role of obstetric doctors during antenatal and intrapartum care varied between women with public coverage versus private coverage. Women with public coverage felt that there was a limited role for the obstetric doctor during antenatal and intrapartum care. These women had full confidence in the abilities of midwives and associated the obstetric doctor with adverse outcomes. Private participants, on the other hand, largely associated the obstetric doctor with positive outcomes, even in the absence of an adverse event. These women considered the role of the obstetric doctor superior to the midwife. Continuity of care with their obstetric doctor dur-

ing antenatal care provided these women with an added sense of security during labour.

I would say [the obstetrician is] crucial. And that's not taking from the role that the midwife has, when I was in [with my last delivery], the midwife that I had for the actual labour was fantastic. But all the time I was thinking 'when is he coming', you know, 'I hope he gets here before because', you know, I felt there was an added sense of safety, or re-assurance. Because he was the person that I had seen, you know, he knew me and I felt that, although that's the training that the midwife does, and again I'm not trying to take from that, but for me, if I'm to be honest, I was much more relaxed once I knew he was there. Participant 9, multiparous, private.

3.2.1.2. Continuity of care with the midwife/obstetric doctor. We observed that women who preferred a midwife to an obstetric doctor revealed a strong preference for continuity of care with the midwife from antenatal to intrapartum care. Many felt that having the same midwife care for them during antenatal and intrapartum care provided a sense of familiarity and reassurance. Those who were concerned about potential complications emphasised that having the same care provider alleviated their concerns since they were not required to repeat their obstetric history at every antenatal visit:

*When I start to go to hospital in the first few weeks I prefer to [have the same midwife] to go into labour with. If I have a choice I prefer no change because it's more comfortable. . . I don't feel comfortable [with a new midwife each time] because I have to explain everything again. **Participant 8, nulliparous, public.***

Some private participants also revealed a preference for continuity of care with a midwife. However, they cited the inability of the public system to provide a sole midwife for the duration of their antenatal care as a major determinant in choosing private care.

*I went privately for that reason. Because I felt I didn't want to be going in every week to see somebody else, somebody different. **Participant 9, multiparous, private.***

3.2.2. Fears around childbirth

Fears around childbirth dominated most sessions, and were a major determinant for many women when choosing place of birth. Women were primarily concerned about timely access to vital services. Three sub-themes were identified: availability and involvement of obstetric doctors during labour, access to neonatal services, and access to pain relief.

3.2.2.1. Involvement of obstetrics doctors during labour (fear of obstetric complication). Many participants felt that the presence of obstetric doctors during labour provided a sense of relief, or safety. Some participants regarded the obstetric doctor as “an insurance policy”, “safe hands”, or “most experienced”. In many other cases participants associated the presence of the obstetric doctor during labour with obstetric complications:

*If he's called in then it's kind of like something. . . might need to be double-checked, like the heartbeat of the baby. **Participant 12, nulliparous, public.***

*A doctor coming into the room when you're in labour is the last thing you want to see. It's almost like seeing a grave digger coming. **Participant 18, multiparous, private.***

This latter view was shared by some private participants, despite the fact that they were directly paying for their obstetric doctor to be actively involved in their intrapartum care.

*It is the one time you hope you don't ever get value for money. **Participant 18, multiparous, private.***

When asked whether they would be interested in delivering in a MLU where care is provided solely by midwives and no obstetric doctors are present, participants gave mixed responses. Some women simply expressed an aversion to MLUs due to a fear of obstetric complications and the subsequent need to be transferred to an obstetric unit in the event of a complication. The following comment highlighted timing as a main concern:

*I'd be nervous about transit time if I had to be transferred, because when things go wrong they can go very wrong, very fast. **Participant 3, multiparous, public.***

When they were informed that the transit time would be minimal in an alongside MLU, as the obstetric unit was attached to the MLU through a connecting corridor, participants were somewhat reassured:

*I wouldn't mind if it was a different location within the hospital. **Participant 3, multiparous, public.***

Another participant said she would have no problem with that, remarking on its close resemblance with the current public system:

*It is actually like that now. I mean unless there is a problem the doctor won't show up. So it's only the midwife, and the doctor is somewhere in the building on call. **Participant 13, multiparous, public.***

Some private participants were averse to the idea of delivering in a MLU. Having spent a considerable amount of money on their care, some women felt they should have immediate and regular contact with their obstetric doctor during intrapartum care.

3.2.2.2. Availability of neonatal services (fear of neonatal complication). Access to a paediatrician and a neonatal unit were cited as important determinants in choosing place of birth. Two participants remarked that they chose to deliver in a large, tertiary maternity hospital outside their catchment area instead of their local maternity unit because of the hospital's wide ranging neonatal services, along with its reputation for care.

Participants were informed that neonatal services are typically provided in obstetric units; however, if they were delivering in an alongside MLU they would have to travel slightly further to access these services. They agreed that once the services were on-site it would not discourage them from delivering in a MLU.

*It's so important that people are there when you need them in an emergency. . . and if your baby has to go to the neonatal unit, then you're not in separate hospitals, that you can just come in and see them. **Participant 3, multiparous, public.***

3.2.2.3. Access to pain relief (fear of pain). Fear of the pain associated with labour and childbirth emerged in each focus group, as best summarised in the following comment:

*My biggest fear is not getting the epidural on time. I've heard horrific stories of people not getting it in time and then they're at nine, ten centimetres and they're told they can't get it now, so that is my biggest fear. And I've heard people say that as soon as you come in start screaming for the epidural, which I am going to do. **Participant 12, nulliparous, public.***

Almost universally, women feared pain; however, there appeared to be a heightened sense of fear among nulliparous women, most likely arising from their lack of experience.

*I'm just really terrified about the idea of pain. **Participant 12, nulliparous, public.***

Most women felt very strongly about delivering in a unit that had the epidural anaesthesia. This was a major feature of maternity care that influenced women's decision-making when choosing place of birth. One participant commented that she did not want to deliver without the epidural:

I just can't imagine going without it. . . please god, just let me have access. **Participant 2, nulliparous, private.**

One nulliparous woman was averse to the epidural given her preference for a quick recovery time and dislike of needles.

I'd love not to have the epidural because I'm all about the recovery time. And I don't like the needle that goes into your back, I'm a bit squeamish. **Participant 16, nulliparous, private.**

When presented with the option of delivering in a MLU, where they would have full access to all methods of pain relief except the epidural, where they would have to be transferred to an adjoined obstetric unit to receive the injection if it became necessary, most women expressed a preference for CLUs:

Labour isn't anyone's finest hour and if one had to be transferred. . . going on a lift and through a public area in the throes of labour. . . no. **Participant 7, multiparous, public.**

Other participants felt that once the MLU was alongside the CLU they would have no problem with it.

If I had to walk through mines I would have done it if it meant that there was going to be light at the other end of the tunnel. **Participant 9, multiparous, private.**

I think you'd go to the edge of the world if you're in enough pain for the epidural. **Participant 4, multiparous, public.**

One woman who was on her third pregnancy and who had received an epidural in each of her previous deliveries declared an interest for midwifery-led care for her upcoming childbirth. The participant believed that reliance on epidural would be minimised in a MLU:

I think I could [deliver in a MLU with restricted access to the epidural]. Not for my first baby, definitely not for my second baby, but at this stage yeah I'd be interested in giving it a go. Because I think the midwives can give you a huge level of support. I think they'd go all in and I think that you would have a better chance of getting through it without an epidural. **Participant 18, multiparous, private.**

3.2.3. Freedom to exercise choice

The freedom to exercise choice during intrapartum and postpartum care was important to all participants. Several women wished to be included in the decision-making around their labour, while others wished to choose their length of stay in hospital after the birth of their baby.

3.2.3.1. Involvement in decision-making during labour. All participants acknowledged that certain decisions require medical expertise, such as the decision to have an emer-

gency Caesarean section. Participants were happy to leave these decisions in the hands of their health care provider given their lack of medical expertise, but some expected to be kept informed at every stage of the process. Few participants did not want to be kept informed. The youngest participant revealed a preference to remain ignorant throughout her entire labour. Her lack of medical knowledge and abiding trust in the medical staff provided her with enough assurance that she did not need to be informed or involved in decision-making.

I think they kind of know what's best though. . . at the end of the day they're not going to do something for no reason, they're going to do what's right for the baby, or they're going to do what's right for you. **Participant 4, multiparous, public.**

The majority of participants felt that they should be involved in the decision-making around other aspects of their labour, such as pain relief.

I think it's important to make those decisions yourself because you're the person that's going through the pain. **Participant 7, multiparous, public.**

3.2.3.2. Length of stay in hospital after birth. Having the option to choose the duration of their stay in hospital after the birth of their baby was an important issue for many participants. The preferred length of stay differed across all women, ranging from six hours to three days. We observed that previous obstetric experience often dictated women's preferences, with those who had given birth before revealing a preference for shorter stays in hospital. One participant who is expecting her fourth child said she would prefer to return home in as few as three to six hours after giving birth "provided everything is ok." Expectant first-time mothers revealed a preference for extended durations of stay, citing inexperience and/or concerns about breastfeeding as the main factors behind their preference.

4. Discussion

This study sought to involve women in the future planning of maternity care by investigating their preferences for care and subsequent motivations when choosing place of birth. It is the first qualitative study to explore women's preferences for alternative models of maternity care in Ireland, and precedes a broader, quantitative exploration of demand for alternative models of maternity care. The results will be used to inform policymakers on whether an expansion of midwifery-led care reflects demand and value for money.

Three themes emerged from the data: continuity of care; fears around childbirth; and freedom to exercise choice during intrapartum and postnatal care. Continuity of care was identified as an important feature of maternity care, irrespective of women's preferences for midwifery- or consultant-led care. We observed that many participants paid for private care to avoid the public system where continuity of care is not guaranteed. Fears around childbirth, in particular fears around timely access to obstetric doctors, pain relief, and neonatal services, dominated all four focus

groups and emerged in each session without prompt by the facilitator. Exercising maternal choice during intrapartum and postpartum care was also identified as particularly important to many women.

While this study represents the first of its kind in an Irish setting, the findings are broadly consistent with findings from other countries where maternal preferences have been sought about consultant- and midwifery-led models of care. A recent systematic review of quantitative studies in the UK [39], which explored women's birth place preferences using stated preference methods and observational studies, found a number of features of care, or attributes, influenced women's decision-making when choosing place of birth, echoing some of the results observed here. For instance, Hollowell et al. [39] found that women valued having immediate access to an epidural, although they may not intend on having it. Women broadly wanted doctors to be readily available on-site in the event of a complication during intrapartum care. Women also wanted to be involved in the decision-making during care. Interestingly, women who preferred consultant-led care expressed a concern about transfer time in the event of an obstetric complication if delivering in a midwifery-led setting, while for those that preferred midwifery-led care, concerns about transfer time were diminished. In this study, we observe that women have a tendency to prefer that which is known to them; consultant-led care. Any deviation from this model of care raised women's concerns about certain aspects of care, such as transfer time to a CLU if delivering in a MLU. It is likely that Hollowell et al. [39] observed something similar. In one of the studies included in the systematic review, Hundley and Ryan [29] found that women preferred attributes that they were more familiar with, such as continuity of care; in regions where continuity of care was more prevalent, women valued this attribute more highly than others. As such, preferences were not simply influenced by experience, but also by knowledge of a service's availability [29], a phenomenon which we observe in the focus groups where women, irrespective of experience, initially favour what they know: consultant-led care.

Experience also plays a role in influencing preferences. In the economics literature, this is referred to as the endowment effect [40] or status-quo bias [41]. In this study, we see some evidence that experience influenced preferences. For instance, women with a history of childbirth revealed a preference for shorter stays in hospital postnatally, compared with first-time mothers. While previous experience may also have influenced their preferences in favour of consultant-led care, it is difficult to examine the extent of this influence with qualitative data, although the phenomenon has been documented elsewhere in the maternity care literature [29,42–45].

In the Netherlands, similar findings were observed for low risk women, in particular involvement in decision-making. Van Haaren-ten Haken et al. [31] investigated women's preferences for key attributes of intrapartum care, comparing women who preferred consultant-led care with those that preferred midwifery-led care. For both groups of women, involvement in decision-making was valued highly. Following the findings presented here, it is

unsurprising that for those intending on giving birth in a hospital setting, the possibility of having pain relief was one of the most important attributes to this group of women. This attribute was less important to women with a preference for midwifery-led care in a hospital setting or at home. Pavlova et al. [34], in an earlier study, compared women's preferences for care with that of their partners. Again, involvement in decision-making ranked as one of the most important attributes to women when choosing place of birth. This was also the most important attribute to women's partners. Interestingly, the possibility of getting pain relief was important, but more so to partners than women. Continuity of care was not explored in either study as continuity of care is provided in the Netherlands and regarded highly by women [46]. de Jonge et al. [46] explored women's experiences following discontinuity of care arising from referral to consultant-led care and found that women valued continuity of care highly as it provided them with a sense of safety during labour. Women were concerned that discontinuity of care may result in important details about their obstetric history and preferences for care being lost during the referral process. Similarly, in this study, we found that women valued continuity of care highly as it provided a sense of safety as they would not have to repeat their obstetric history with each healthcare provider, minimising the risk of important details about their pregnancy being lost.

Evidence from other countries is limited. In Canada, a mixed methods study was undertaken to understand the factors that influence women's decision-making when choosing between a hospital-based birth and home birth [37]. Similar to this study, women were largely concerned about safety issues, access to pain relief, and involvement in decision-making. Unsurprisingly, women with a disposition towards a hospital-based birth attached a greater priority to pain relief than those with a preference for a home birth, who wished to avoid such interventions. For this group, it was important that the childbirth experience was a natural process. In this study, we observe that the majority of women, when choosing between consultant- and midwifery-led care, attached considerable importance to pain relief. Women were largely in favour of the intervention and wanted it to be readily available on-site. However, we do not capture the preferences of women that prefer home births, which may have been similar to those observed by Murray-Davis et al. [37].

A major strength of qualitative research lies in its ability to identify important trade-offs consumers face when evaluating services [47]. The findings presented here identify important trade-offs women face when choosing place of birth. For instance, continuity of care and fears around timely access to medical services were important to most participants. In a MLU, continuity of care is assured whereas it may occur unintentionally in a CLU. When presented with the choice of care in a MLU or a CLU, women have to weigh up the benefit of assured continuity of care in a MLU against the cost of reduced access to medical services such as an obstetrician or epidural anaesthesia, which are immediately available in a CLU. While qualitative research is crucially important in identifying preference trade-offs, it is restricted in exploring the extent and magnitude of

these trade-offs; quantitative research is further required to explore these trade-offs in detail.

The policy implications arising from this research are immense as they shed light on the expected behaviour of women when choosing between an existing model of care and a newly implemented model of care. Policymakers, when introducing midwifery-led care, now know that some of the major concerns women will have about utilising the new model of care relate to safety, stemming largely from the information asymmetry that will initially exist. As such, informative discourse between the health care provider and woman in the presence of consumer choice is considerably important. Fears around timely access to vital services were a dominant theme in each focus group. These fears could be addressed with informative dialogue between the health care provider and pregnant woman about the risks associated with delivering in a MLU, and the length of transit time from the MLU to a CLU. For instance, a randomised controlled trial found that there was no significant difference between adverse outcomes in a MLU and CLU in Ireland and average transit time from the MLU to the CLU took 0–15 min [3,4]. Although 17% of women delivering in the MLU were transferred to the adjoined CLU, this included minor indications, such as temporary transfer for an epidural upon maternal request [3,4]. When women in the focus groups were informed that essential medical services would still be available on-site, their reservations about midwifery-led care were relaxed with some participants declaring a preference to deliver in an alongside MLU.

Overall, the results suggest that women may prefer MLUs when co-located with existing CLUs. While safety concerns largely influenced women's preferences, the results also suggest that women do not have a clear preference for either model of care, but rather a hybrid model of care which encompasses features of both consultant- and midwifery-led care. Women expressed a preference for continuity of care with a midwife with many women opting for private care given the public system's inability to assure continuity of care. Women then want to deliver in a maternity care setting where the full range of medical services is immediately available or available on-site. This suggests that the DOMINO scheme may be preferred by maternity users as it closely resembles the preferences presented here [16].

We acknowledge there are limitations in this research. The total number of participants in the focus groups was smaller and the rate of opt-out was higher than anticipated. The views and opinions of women who did not participate including non-English speakers (who could not participate) may have differed considerably from the views and opinions of the sample. The rate of uptake among private participants was disproportionately larger than among their public counterparts. This research invited women who had already declared a preference for secondary care to participate in the study. The views and opinions of women who prefer home birth care are missed in this analysis. However, in Ireland, less than 1% of women opt for a home birth [3]. In addition, the preferences of women who live in a catchment area where both models of care are provided are missed in this analysis. It is possible that the

preferences of women who have experienced midwifery-led care may differ to the views presented here.

5. Conclusions

This is the first time women were consulted about their views of and preferences for maternity care in an informal setting in Ireland. The results demonstrate that continuity of care, fears around timely access to medical services, and the freedom to exercise choice are important features of maternity care that influence women's decision-making when choosing place of birth. Reassuringly, the findings are broadly consistent with the international literature. Whether women choose consultant-led care, midwifery-led care, or opt for private care in Ireland, the general attitude towards maternity care seems positive, and is best summarised by the following comment:

The system is really quite good and I suppose the package of care that you get, public or private, isn't that different, you know. I think we're very lucky. Participant 3, multiparous, public.

Disclosure of interests

All authors have nothing to declare.

Ethical approval

This study was granted ethical approval from University College Cork Clinical Research Ethics Committee review (ECM4 06/03/12) and the Division of Obstetrics and Gynaecology, Cork University Maternity Hospital.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.healthpol.2016.10.010>.

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